Complete Summary

GUIDELINE TITLE

Medication management guideline.

BIBLIOGRAPHIC SOURCE(S)

Health Care Association of New Jersey (HCANJ). Medication management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2006 Apr. 33 p.

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Adult medical conditions requiring pharmacological management
- Adverse effects occurring because of medication errors

GUIDELINE CATEGORY

Management
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Geriatrics

Internal Medicine
Nursing
Physical Medicine and Rehabilitation

INTENDED USERS

Allied Health Personnel
Health Care Providers
Nurses
Pharmacists
Physicians
Utilization Management

GUIDELINE OBJECTIVE(S)

To provide information, tools and systems that are intended:

- To reduce medication errors in health care facilities
- To improve the quality of care and quality of life for adults living or convalescing in health care facilities
- To outline strategies for prescribing, dispensing, delivering, storing, administering and monitoring medications
- To reduce risk and professional liability

TARGET POPULATION

Adult patients/residents in sub-acute care facilities, comprehensive personal care homes, skilled nursing facilities, assisted living programs, nursing facilities, residential health care facilities, assisted living facilities, adult day health facilities, or hospice programs

INTERVENTIONS AND PRACTICES CONSIDERED

Strategies for prescribing, dispensing, delivering, storing, administering, and monitoring medications at the following risk points:

1. During admission from home, transfer between hospital or other facilities, and discharge to home
2. When making telephone orders for medication
3. When making written orders for medications
4. During transcription of orders for medication
5. During provider pharmacy receipt of medication orders
6. During provider pharmacy dispensing of medication
7. During receipt of medications at facilities/programs
8. During pharmacy restocking of medication
9. During medication administration
10. While monitoring therapeutic benefits and adverse consequences of medication
11. While stocking medications (including back-up and emergency boxes)
12. During resident self-administration of medication
13. When residents or their families bring medication from home

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The development process included a review of government regulations, literature review, expert opinions, and consensus. The guidelines are consistent with these principles:

- Relative simplicity
- Ease of implementation
- Evidence-based criteria

- Inclusion of suggested, appropriate forms
- Application to various long term care settings
- Statutory and regulatory requirements
- Utilization of minimum data set (MDS) resident assessment instrument (RAI) terminology, definitions and data collection

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions

Adverse Consequence: An effect that is due to or associated with a medication and that is manifested as an unpleasant symptom, or that impairs or causes a decline in an individual's health, physical condition, or functional or psychosocial status. It may include various types of adverse drug reactions and interactions.

Adverse Drug Reaction (ADR): A type of adverse consequence that is a secondary effect of a medication that is undesirable and different from the helpful and therapeutic effects of the medication. It may include a side effect, hypersensitivity, idiosyncratic response, toxic reaction or medication interaction.

Adverse Medication Event: Includes adverse consequences, adverse drug reactions and medication errors.

Anticholinergic Side Effects: Effects of a medication that oppose or inhibit the activity of the parasympathetic (cholinergic) nervous system to the point of causing problematic or undesirable symptoms such as dry mouth, blurred vision, tachycardia, urinary retention, constipation, confusion, delirium or hallucinations.

Behavioral Interventions: A type of non-pharmacological approach to try to influence or redirect behavior; for example, by talking with the individual,

restructuring the environment, discussing and enforcing limits on acceptable behavior, or various psychosocial and activities interventions. (See non-pharmacological interventions)

Clinically Significant: Effects, results, or consequences that materially affect or are likely to affect an individuals physical, functional, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

Extrapyramidal Side Effects: Signs and symptoms related to impairment of the extrapyramidal nervous system, such as tremors, postural unsteadiness, slowness of movement, expressionless face, drooling, shuffling gait, akathisia (physical symptoms of restlessness or constant motion, such as inability to sit still, fidgeting, pacing, rocking) or rigidity of muscles in the limbs, neck, and trunk.

Gradual Dose Reduction (GDR): The stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Indications For Use: The identified, documented clinical rationale for administering a medication based upon an assessment of the resident's condition and therapeutic goals and on manufacturer's recommendations.

Medication Error: A medication error is any preventable event that may cause or lead to inappropriate medication use or resident harm while the medication is in the control of the health care professional or resident. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. Includes "near miss."

Medication Interactions: The impact of another substance (such as another medication, herbal product, food or substance used in diagnostic studies) upon a medication. The interactions may result in alterations of absorption, effectiveness, duration of therapeutic effect, circulatory transport, inactivation, excretion, or potential for adverse consequences.

Monitoring: The ongoing collection and analysis of information (including observation and diagnostic test results, etc.) and comparison to baseline data in order to: (a) ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal, and detection of any complications or adverse consequences of the condition or of the treatments; and (b) support decisions about modifying, discontinuing, or justifying the continuation of any intervention.

"Near Miss" Medication Error: An occurrence that would have otherwise resulted in a medication error where it not for the pre-error identification and intervention.

Non-pharmacological Interventions: Approaches to care that do not involve medications, generally directed towards stabilizing or improving a resident's condition and/or behavior. Examples of such approaches include alternate or complementary therapies to address pain, identifying and reducing environmental and psychosocial stressors, basing daily care on customary or life-long routines, encouraging involvement in person-appropriate activities, using sleep-hygiene techniques, etc. (See Behavioral Interventions)

Psychotherapeutic Medication: Any medication traditionally identified as a psychotropic (e.g., antipsychotics, anxiolytics, antidepressants, central nervous system stimulants, sedatives, and hypnotics) or any medication prescribed with the intent to manage or treat psychiatric disorders or distressed behavior or mood (such as mood stabilizers, anti-manic medication, cognitive enhancers, anticonvulsants).

Reconciliation: Medication reconciliation is the process of comparing a resident's medication orders to all of the medications that the resident has been taking.

Risk Point: An identified stage of a process that has an elevated potential for the occurrence of an adverse medication event.

Side Effect: An expected, known reaction that occurs with a predictable frequency and is less intense or problematic than an ADR. Side effects of minimal impact or duration do not necessarily constitute adverse consequences. Consideration of side effects may be a key factor in selecting particular medications.

Tardive Dyskinesia: A syndrome (often medication-related and sometimes irreversible) that affects parts of the nervous system associated with movement. It is characterized by abnormal, involuntary movements, such as recurrent oral facial movements, lateral movements of the tongue, tongue thrusting, chewing, or lateral jaw movements, frequent blinking, brow arching, grimacing, and lip smacking. Although commonly associated with antipsychotic medications, the syndrome may occur with various other medications (such as metoclopramide) and medication combinations.

<u>Risk Points and Risk Reduction Strategies</u>

Note: A Risk Point is an identified stage of a process that has an elevated potential for the occurrence of an adverse medication event.

A. Risk Point: Admission, Transfer Orders, And Discharge To Home
    1. Admission from home
    2. Transfer between hospitals and facilities/programs
    3. Transfer within facility/programs
    4. Discharge to home

    Risk Points and Risk Reducing Strategies: Medication Reconciliation and Clarification

1. Admission from home: Reconcile proposed new orders with past medication usage.
    a. Review labels of all medication containers from home including over-the-counter medications and supplements.
    b. Review all community physician documentation available.
    c. Clarify any discrepancies or questionable orders with original source as necessary.

2. Admissions/transfers from hospitals and other facilities: Reconcile
    a. Obtain and review copy of Medication Administration Record/Treatment Administration Record (MARs/TARs), transfer form, and Physician's Order Sheets (POS). Verify MAR/TAR information with transfer form and POS if available. Do not rely solely on transfer form.
    b. Clarify all medication orders with clinical staff from transferring hospital/facility when necessary.
    c. See item 5. below

3. Readmissions:
    a. Compare transfer orders and information with previous medical record and clarify any discrepancies. Do not administer previously ordered medications without a renewal order.

4. Consultant initial review:
    a. Initial orders faxed [fax original documents, not copies] to pharmacy consultant for timely review and written comments which are faxed back to the facility for inclusion in the medical record.
        i. Facility communicates the following information to the pharmacy consultant: resident's full name and date of birth, sex, weight, allergies, full medication orders, doses, diagnosis (indications for use) and laboratory reports.

5. Transfer Document: Reconcile
    a. Transfer forms will include printed, up-to-date medication orders with related diagnosis (indications for use) and relevant laboratory data.
        i. Inter-facility/program transfer form signed by physician.
    b. Transfer form will include current and historic influenza and pneumonia vaccine information.
    c. Transfer documents will include up-to-date patient/resident care plan with physician's orders.
    d. Receiving facility/program nurse/physicians or pharmacists will review medications and immunization information with resident and/or knowledgeable and authorized resident representative to confirm accuracy of information.
        i. Ask family to bring at home medications, supplements, and over-the-counter drugs to the facility to reconcile past medications usage with proposed, new orders.
    e. Receiving facility/program will clarify all medication orders by cross-checking medications shown on MAR, POS and Transfer

Form. Contact the clinical staff of the transferring hospital/facility to clarify the orders as necessary.

f. Reconcile proposed, new orders with past medication usage.
g. Transfer protocol for intra-facility/program transfers will include a verbal communication of the resident's current physical and mental status, review of the medications and the care plan. Receiving nurse will document evidence of the clinical report.

6. Discharge To Home
    a. Reconcile medications: Prior to discharge to home, family will bring all at-home medications (including over the counter (OTC) and herbal substances) to the facility/program for the physician/nurse/pharmacist to review along with current medications. Discharge orders, prescriptions, and instructions to resident/family should clearly identify which medication should be continued at home.
        i. Send discharge medication and care plan information to community physician and/or home care program.
        ii. Provider pharmacy sends resident/medication specific drug information document to facility.
            - Facility gives drug information document to resident/family with list of medications to be taken at home. Educate resident and family about therapeutic benefits, side effects and adverse consequences.

B. Risk Point: Telephone Orders for Medication

Except for telephone orders, verbal orders should not be accepted, except in emergencies.

Risk Reduction Strategies

1. Facility informs the prescriber of the following information:
    a. Resident's full name, age, sex and weight
    b. Diagnoses
    c. Drug and food allergies
    d. All prescribed current medications
    e. Recent signs and symptoms
    f. Recent laboratory data

2. Read Back: receiving nurse will listen to prescriber, write down orders on appropriate document and read back the resident's full name and prescription orders as the nurse has written them. Prescriber will verbally verify accurate read back.
3. Telephone orders are faxed [fax original document, not copy] to the prescriber for prescriber review, signature and timely return fax.
    a. Prescriber will immediately telephone facility/program if faxed orders are incorrect and in need of adjustment.

4. Educate staff to be watchful of sound-alike medications. Post facility-specific sample list at all nurses/medication stations. See sample list of the Institute for Safe Medication Practices (ISMP) at www.ismp.org.

C. Risk Point: Written Orders For Medication

Written orders include signed orders that may be handwritten, computer generated or faxed.

Risk Reduction Strategies

1. Orders are entered on documents that identify the resident's complete first and last name.
2. Orders are dated and timed as written.
3. Orders include full name of medication, dose, route of administration, time(s) of administration, related diagnoses/indications for use, and duration.
4. Avoid abbreviations. Alternatively, use the Institute for Safe Medication Practices (ISMP) guidelines. (see exhibit on pages 29-30 in the original guideline document)
5. Review and compare orders with the list of dangerous drug-to-drug interactions and high risk drugs. (see exhibit on page 28 in the original guideline document)
6. Implement facility approved medication-specific laboratory monitoring protocols. (see exhibit on page 31 in the original guideline document)
7. Implement facility-defined protocols for assuring accurate monthly review of orders and MAR/TARs.
8. Nurse and/or pharmacist will note all illegible, incomplete or otherwise questionable orders and immediately seek clarification from the prescriber before transcribing or dispensing the medication orders.
9. Educate staff to be watchful of look-alike medications. Post facility-specific list at all nurses/medication stations. See sample list of ISMP at www.ismp.org.
10. Fax original documents, not copies.

D. Risk Point: Transcription of Orders for Medication

Transcription of orders means nurses or other authorized staff write the orders on the MAR or TAR.

Risk Reduction Strategies

1. Nurse/authorized designated transcriber enters the complete order onto the MAR/TAR with the prescriber's order sheet in view of and adjacent to the MAR/TAR. Leave a blank space between each medication order.
    a. Second nurse/authorized transcriber reviews the order transcription by verifying that the information in the MAR/TAR is the same as the order. Note: Facility/program protocols should specify the process for the transcribing and verifying staff to sign or initial the order sheet and the MAR/TAR to

establish the identity of who completed the transcription and verification process.

2. Facility/program protocols may include a process for a designated staff person to review all orders for the previous 24 hour period, and confirm that all orders were accurately transcribed.
3. Consult facility/program's "like names alert" policy to assure correct resident's name.

E. Risk Point: Provider Pharmacy Receipt of Medication Orders

Risk Reduction Strategies

1. Information shared with the provider pharmacy will include resident's full name, age or date of birth, sex, weight, allergies, diagnoses (indications for use), and pertinent laboratory reports.
2. Complete, legible medication orders include the resident's full name, date, drug, dose, route times of administration, and duration.
3. Provider pharmacy establishes resident-specific medication regimen.
    a. Assess for drug interaction and otherwise review appropriateness of the medication regimen.
    b. Immediately notify prescriber and facility if potential drug interaction or the potential for harm from medications is identified.

F. Risk Point: Provider Pharmacy Dispensing of Medication

Risk Reduction Strategies

1. Provide precautionary instructions and parameters for use on medication label and/or MAR/TAR.
    a. Provide individual medication information sheet with therapeutic use, side effects and adverse consequences.

2. Package medication in a manner to promote a safe and efficient medication administration system.
3. When generating Physician Order Sheets (POS), include all facility approved, medication-specific protocols for laboratory reports and other clinical measurements.
4. Comply with established facility protocols for timely, safe delivery and receipt of medication.

G. Risk Point: Receipt Of Medications At Facility/Program

Risk Reduction Strategies

1. Match all medications with corresponding records.
2. Properly safeguard medications. Place in proper location, such as locked cart, locked room, medication refrigerator, and controlled drug inventory area.

H. Risk Point: Provider Pharmacy Restocking of Medication

Risk Reduction Strategies

1. Licensed pharmacist to verify correct name and dose of returned medications.
2. Two (2) staff members will verify correct container for each medication and will complete accurate restocking process

I. Risk Point: Medication Administration

- RIGHT Patient
- RIGHT Medication
- RIGHT Dose
- RIGHT Route
- RIGHT Time
- RIGHT Documentation

Risk Reduction Strategies

1. Strict compliance with established protocols, including:
    a. New medication order—first dose
        i. Check POS to confirm accuracy of MAR/TAR before administering first dose.

    b. Read and compare MAR/TAR and medication labels three (3) times:
        i. Initial view.
        ii. At pouring.
        iii. After pouring.

2. Use two (2) forms of resident identification, including
    a. What is your name?
    b. ID bracelet.
    c. Photo (update photo annually).
    d. Staff verification.
    e. Follow "like names alert" policy to avoid similar resident's name errors. Note: Do not use room or bed number.

3. Observe for expected therapeutic effects, side effects, and adverse consequences. Communicate side effects and adverse consequences to supervisor and prescriber.
    a. May "hold" medication in accordance with professional standards.

4. Follow precautions and assess and record clinical parameters.
    a. Administer and observe as resident takes medication.
    b. Document the process.

5. Follow appropriate infection control standards.

J. Risk Point: Monitoring Therapeutic Benefits and Adverse Consequences of Medication

Risk Reduction Strategies

1. Consult readily available medication information reference sources that may include:
    a. Current Physician's Desk Reference (PDR)
    b. Current drug handbook
    c. Computer information system
    d. Pharmacy provided information sheets
    e. Other references

2. Advise prescriber of identified adverse consequences or failure to obtain therapeutic benefits.
3. Follow facility protocols for high risk medications and laboratory monitoring.
4. Follow facility protocols for avoiding potentially dangerous drug-to-drug and drug/food interactions.
5. Identify resident-specific non-pharmacologic interventions (behavioral) that are considered and used instead of, or in addition to, psychotherapeutic medications.
6. Whenever there are changes in the resident's mental or physical functional status, "Think Medications." Clinical team will evaluate medication regimen as a potential contributing factor and revise medication orders as appropriate.

K. Risk Point: Stock, Back-Up Box, and Emergency Box Medications

Risk Reduction Strategies

1. Facility identifies specific contents and protocols for use.
    a. Review and revise contents at least annually.

2. Monthly monitor stock levels and expiration dates and restock as necessary.

L. Risk Point: Resident Self-Administration of Medication

Risk Reduction Strategies

1. Carefully assess capacity of resident to safely store and self-administer medication.
    a. Reassess resident capacity to self-administer at least quarterly.

2. Educate resident regarding the following:
    a. Indications for use and expected benefits.
    b. Method of administration.
    c. Side effects and adverse consequences.

3. Provide for proper storage.

4. Staff will monitor and record indications of therapeutic benefits, side effects and adverse events, and keep prescriber informed.

M. Risk Point: Resident / Family Brings Medications from Home

Risk Reduction Strategies

1. Limit medications from home brought to facility.
2. Educate residents and families about facility policy on medications from home.
    a. Include policy in admissions agreement.

3. Require that medications from home be properly labeled and packaged, including physician provided samples.

Safety-Related Recommended Policies

Policies To Include

- Stop Order
- Medication Errors
- Adverse Drug Reactions
- Laboratory Monitoring
- Anticoagulation
- Controlled Drugs
- Self Medication
- Abbreviations
- Read Back
- High Risk Medications

Controlled Drugs - Additional Steps to Consider

1. New orders: confirmation for C II, faxing.
2. Refills: labels should be used (nurses should not handwrite), consider having supervisor fax all refills for controlled on separate sheet (not with other med refills).
3. Receipt of drugs: consider having supervisor receive all controlled, check that seal is intact and count all drugs, and note receipt in entry logbook.
4. One nurse should be responsible for putting controlled drugs in carts.
5. Consider having a log to count all sheets so bingo cards cannot be diverted along with their sheets. Nurse to add to count when drugs are added to carts.
6. Nursing supervisor should remove drugs for destruction and update the sheet count.
7. Keep destruction log. Enter drugs to be destroyed in log and keep log in location other than where the drugs are kept. Two (2) nurses or pharmacists to count drugs to be destroyed and sign log.
8. Assign responsibility for back-up controlled. Should be counted every shift by 2 nurses
9. All completed count sheets (drugs used up or destroyed) to be matched to entry log.

10. When counting at change of shift, always have both nurses present and counting. Count should be done also when leaving cart assignment (hand over the keys) during shift.
11. Periodically review (nursing and/or pharmacy consultant) the use of prn controlled substances, looking for trends.
12. Keep list of Prohibited Abbreviations current:qd, qod, hs, U, IU, .X, X.0, MS, MSO4, MgSO4, ug, OD, OS, OU, AD, AS, AU, tiw.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Reduction in medication errors
- Improved quality of care and quality of life

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use by your organization, it should be reviewed by counsel knowledgeable concerning applicable federal and state health care laws and rules and regulations. This guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

The Best Practice Guideline is offered to nursing facilities, assisted living facilities, residential health care facilities, adult day health services providers and other professionals for informational and educational purposes only.

The Health Care Association of New Jersey (HCANJ), its executers, administrators, successors, and members hereby disclaim any and all liability for damage of

whatever kind resulting from the use, negligent or otherwise, of all Best Practice guidelines herein.

The Committee's development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strives to develop guidelines that are consistent with these principles:

- Relative Simplicity
- Ease of Implementation
- Evidence-based criteria
- Inclusion of suggested, appropriate forms
- Application to various long term care settings
- Consistent with statutory and regulatory requirements
- Utilization of MDS (RAI) terminology, definitions and data collection

Appropriate staff (Management, Medical Director, Physicians, Nurse-Managers, Pharmacists, Pharmacy Consultants, Interdisciplinary Care Team) at each facility/program should develop specific policies, procedures and protocols to best assure the efficient, implementation of the Best Practice guideline's principles.

The Best Practice Guidelines usually assume that recovery/rehabilitation is the treatment or care plan goal. Sometimes, other goals may be appropriate. For example, for patients receiving palliative care, promotion of comfort (pain control) and dignity may take precedence over other guideline objectives. Guidelines may need modification to best address each facility, patient and family's expectations and preferences.

Limited Scope of Medication Management Guideline

The HCANJ Best Practice Committee ("Committee") constructed a limited scope guideline intended to assist health care providers with the development and implementation of systems and strategies that the Committee believes will reduce medication errors in health care facilities. (see section III of the original guideline document)

- Providers interested in expanding their information-base beyond this Guideline are referred to page 33 of the original guideline document for a list of topic-related internet sites.
- This Guideline does not include information about the clinically appropriate use of specific medications. It is not intended to be used as a resident-specific or medication-specific guideline.
- The Guideline assumes that all services are provided in accordance with regulatory requirements and standards of professional practice.
- This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use, it should be reviewed by counsel knowledgeable concerning applicable federal and state health care laws and rules and regulations. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Quality Improvement Process Addresses The Following:

1. Assurance of written protocols for pharmacy and medication systems.
    a. System to include accountability of prescriber, facility staff, pharmacy provider and pharmacy consultant.
    b. Protocols to include methods to evaluate competency of staff, identification of learning needs, and the provision of appropriate education to establish and maintain staff competency.

2. Protocols for identification, reporting and analysis of adverse medication events and "near misses."
    a. Analysis of Adverse Drug Reactions (ADR) to include probability, preventability and severity. (exhibit included in original guideline)
    b. Medication errors are placed in categories to facilitate analysis. (exhibit included in the original guideline document)
    c. Conduct root cause analysis of errors. Review and revise policies, procedures and protocols to reduce or eliminate likelihood of similar errors.

3. Implementation by Medical Director of defined protocols to monitor prescribing patterns of the medical staff and medical staff education and/or other corrective actions as appropriate.
    a. Provider pharmacy produces summary reports of patterns of prescribing for each member of the medical staff.
    b. Medication order checklist audit tool. (exhibit included in original guideline)

4. Protocols for consultant pharmacist to observe medication administration of newly-employed staff authorized to administer medication and to periodically observe staff on all shifts.
    a. Conduct an analysis of observations, review medication administration policies and procedures and identify and implement corrective measures as indicated.

5. Define process for analysis of available information and selective changes in policy, procedures, protocols and education intended to address identified opportunities to improve quality, including controlled drug procedures.
6. Frequent review and careful monitoring of anti-coagulation therapy and other medication-related laboratory test monitoring protocols.
7. Maintain confidential documentation of Quality Improvement (Q.I.) monitoring, reviews, analysis, conclusions and modifications in policies, procedures and protocols.

Education

Facilities/programs will develop education program content specific to their policies, procedures and protocols.

A. STAFF EDUCATION

Staff includes those who transcribe, administer and monitor medication.

1. Orientation.
2. Periodic reviews and updates.
3. Re-education following changes in policies, procedures and protocols.
4. Readily available, current drug reference text and/or The Physicians Desk Reference (PDR).

B. RESIDENT/FAMILY EDUCATION
1. Upon admission.
2. On-going as indicated.
3. Self-medication information.
4. Upon planned discharge.

C. PRESCRIBER EDUCATION
1. Upon joining, medical "staff" or otherwise approved attending or consulting prescriber status.
2. Periodic reviews and updates, including issues identified by consultant and provider pharmacists.
3. Re-education following changes in policies, procedures and protocols.

D. EDUCATION PROCESS
1. Education may occur:
    a. One-on-one.
    b. On-site or off-site training.
    c. Via internet learning.
    d. Via self study.

2. Readjust education plans in response to opportunities to improve as identified through the Q.I. Process.
3. Maintain all education records including topics and attendance.
    a. Individual employee education record will include date, duration and topic.

Also see the section titled "Intended Use of Medication Management Guideline" in the original guideline document for information on how specific users (e.g., pharmacists, medical directors, physicians) can use this guideline. In addition, a number of medication management tools are provided in the original guideline document.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Chart Documentation/Checklists/Forms
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Health Care Association of New Jersey (HCANJ). Medication management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2006 Apr. 33 p.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Apr

GUIDELINE DEVELOPER(S)

Health Care Association of New Jersey - Private Nonprofit Organization

SOURCE(S) OF FUNDING

Health Care Association of New Jersey

GUIDELINE COMMITTEE

Best Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Health Care Association of New Jersey Web site.

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

AVAILABILITY OF COMPANION DOCUMENTS

The following implementation tools are available in the original guideline document:

- Medication Reconciliation Form
- Medication Occurrence / Error Report
- Provider Pharmacy Report
- Medication Occurrence / Error Tracking Checklist
- Medication Order / Prescription Tracking Checklist
- Medication Administration Monitoring Form
- Dangerous Drug Interactions In Long Term Care
- ISMP's List of Error-Prone Abbreviations, Symbols, and DoseDesignations
- Medication Related Laboratory Test Monitoring Policy (Sample guideline)
- Naranjo's Algorithm—ADR Classifications

Electronic copies: Available in Portable Document Format (PDF) from the Health Care Association of New Jersey Web site.

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 14, 2006. The information was verified by the guideline developer on August 15, 2006.

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